Cabinet for Health and Family Services
Department for Medicaid Services
Frankfort KY 40621

907 KAR 1:038 and E
Material Incorporated by Reference

Vision Program Manual
May 2006 Edition

Hearing Program Manual
May 2006 Edition

Filed:

Kentucky Medicaid Program

Vision Program Manual

Policies and Procedures

Cabinet for Health and Family Services
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SECTION I - INTRODUCTION

A. Introduction

The Kentucky Medicaid Vision Program Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual contains basic information concerning coverage and policy. Precise adherence to policy shall be imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

KENTUCKY MEDICAID PROGRAM

SECTION II

SECTION II - KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients. The Medicaid Program shall be the payor of last resort. If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable charge.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policy are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provider Medicaid services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, recipients may select the provider from whom they wish to receive their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same services shall not be tendered to the

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

B. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulation define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45(d) (5) as follows, "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing **RECEIPT** by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. **ONLY** twelve (12) months shall elapse between **EACH RESUBMISSION** of the claim by the Program.

C. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary physician or family doctor. The primary physician shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

Optometry and ophthalmology services shall not be affected by KenPAC. You should continue to bill as usual for any covered services provided to patients with a "green" MAID card.

CONDITIONS OF PARTICIPATION

SECTION III

SECTION III - CONDITIONS OF PARTICIPATION

A. General Information

For purposes of participation in the Kentucky Medicaid Program, a Medicaid provider number shall be assigned to each provider. Optometry provider numbers have a prefix of "77". Optician provider numbers have a prefix of "52". Failure to report the correct provider number on the claim submitted for services provided may result in incorrect or nonpayment of claims. If a provider is terminated or suspended from Kentucky Medicaid participation, services provided to Kentucky Medicaid recipients after the effective date of termination or suspension shall not be payable.

B. Licensure

All optometrists shall be certified by the Kentucky Board of Optometric Examiners or in the state in which they practice and be required to submit proof of licensure. Annual proof of licensure renewal (which includes effective date and expiration date) shall be required and submitted to the Kentucky Medicaid Program, Individual Provider Services Branch for providers who desire to remain actively enrolled.

All opticians shall hold a current license in the Commonwealth of Kentucky as ophthalmic dispensers and conduct business in accordance with KRS Chapter 326. Out-of-Kentucky opticians shall be required to submit proof of licensure and license renewal as dictated by their respective state boards. Annual proof of licensure renewal (which includes effective date and expiration date) shall be required and submitted to the Kentucky Medicaid Program, Provider Enrollment Section for providers who desire to remain actively enrolled.

NOTE: Non-submission of proof of current licensure shall result in loss of eligibility of the provider **and** denial of claims submitted for payment.

SECTION III - CONDITIONS OF PARTICIPATION

E. Medical Records

Medical records shall substantiate the services billed by the optometrist. The medical records shall reflect the nature and extent of counseling and coordination of care and be supportive of medical necessity. Optometrist notes shall be contained in these medical records. These notes shall be entered personally by the optometrist or typewritten if signed by the optometrist. **ALL** records shall be signed, dated, and include the following:

Recipient's identifying data
Complete vision analysis and therapy records
Prescriptions
Visual field charts
Orthoptic evaluation records
Orthoptic records
Tonograms
Fitting measurements, identifying lens and frame specifications
Any other documentation which supports the medical necessity of the services performed

In the office or other outpatient setting, counseling and coordination of care shall be provided in the presence of the recipient (patient) if the time spent providing those services is used to determine the level of care (service) reported. The duration of counseling or coordination of care that is provided face-to-face may be estimated; however, that estimate, along with the total duration of the visit, shall be recorded when time is used for the selection of visit that involves predominately coordination of care and counseling.

Medical records shall substantiate the services billed by the ophthalmic dispenser. The medical records shall reflect the nature and extent of counseling and coordination of care and be supportive of medical necessity. Optician notes (if any) shall be contained in these medical records. These notes may be entered personally by the optician or may be typewritten if signed by the optician. **All** records shall be signed, dated, and include the following:

Addendum (MAP-380). If a third party computer billing agency is used to prepare the media for the provider, the electronic media billing agency shall also complete and submit an agreement (MAP-246). One (1) copy of each completed form shall be returned to the Department for Medicaid Services.

Optometry providers located outside the United States and its territories shall not be granted enrollment in the Kentucky Medicaid Program.

Notification in writing shall be made to the Medicaid Program regarding any change in Program participation status (e.g., change of ownership, address change, closing).

G. Overview of Required Procedures

The Medicaid Program shall use several investigative and screening methods to detect any abuse on the part of the provider or recipient. Computer print-outs shall be reviewed periodically (e.g., quarterly). Data shall be compared against norms of the specific medical service areas for number of medical services per recipient, cost per service and cost per recipient. If the figures show significant deviations from the norms, the provider shall be identified as needing an in-depth review. Records shall be more thoroughly examined and provider and recipient contact shall be initiated to determine the cause for the unusual pattern or care.

PROGRAM COVERAGE

SECTION IV

SECTION IV - PROGRAM COVERAGE

COVERAGE REQUIREMENT

(1) Prior to the delivery of a covered hearing or vision service, the service shall be determined by the department to be:

(a) Medically necessary; and

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.

(2) The requirements established in subsection (1) of this section shall not apply to an emergency service.

IV. PROGRAM COVERAGE

A. Eligibility Guidelines

Medical Assistance Identification (MAID) cards shall be issued to all recipients eligible for program benefits. The ten (10) digit MAID number which appears on the identification card shall be entered in Field 9a on the HCFA–1500 claim form submitted for payment. It is recommended that the provider or providers staff correctly identify the recipient whose name appears on the card at the time of service delivery and carefully note the period of eligibility to validate that the recipient is eligible for benefits on the date of service. A second form of recipient identification may be requested by the provider in order to verify the identity of the recipient. Kentucky Medicaid shall not reimburse for services provided to an ineligible recipient. **The Kentucky Medicaid program shall not cover vision services for any individual age twenty-one (21) and over.**

B. Examination, Diagnostic and Treatment Services

The HCFA-1500 claim form (revised 12/90) shall be used to report vision services to eligible Medicaid recipients. This specific form shall be submitted completely, accurately, and legibly to the Kentucky Medicaid fiscal agent within twelve (12) months from the date of service or within six (6) months of the Medicare or other insurance adjudication date. Specific guidelines for completion of the HCFA-1500 shall be available through the fiscal agent. Actual signatures of the provider or authorized others shall be required on claims submitted for payment.

The Kentucky Medicaid Program shall provide reimbursement to optometrists for vision examinations and limited diagnostic and treatment services provided for eligible recipients (**no one age twenty-one (21) or over**) according to the Physicians Current Procedural Terminology/Health Care Financing Administration Common Procedural Coding System (CPT codes) reported on claims and ONLY as the descriptors of the codes allow. Kentucky Medicaid shall announce occasions when code descriptors are not recognized or are altered for Kentucky Medicaid reimbursement purposes. If protocols in the CPT are more stringent than limits stated in this Section, the protocols in the CPT shall take precedence.

*Procedure code 92070 shall be used to bill the therapeutic bandage lens used in the treatment of diseases, (e.g., bullous keratopathy or non-healing corneal ulcers).

Contact lenses are non-covered and shall not be substituted as eyeglasses.

2. Limitations on Covered Examination, Diagnostic and Treatment Services

Effective 12-01-93, **new** patient Evaluation and Management office or other outpatient services codes 99201, 99202, 99203, 99204 and 99205 shall be limited to one (1) per recipient, per provider, per three (3) year period.

Established patient Evaluation and Management office or other outpatient services codes 99214 and 99215 shall be limited to one (1) per recipient, per provider, per twelve (12) month period.

Effective 12-01-93, **new** patient Evaluation and Management home services codes 99321, 99322, 99323, 99342, 99342, and 99343 shall be limited to one (1) per recipient, per provider, per three (3) year period. Established Evaluation and Management home service code 99353 shall be limited to one (1) per recipient, per provider, per twelve (12) month period.

Effective 12-01-93, **new** patient ophthalmological procedure codes 92002 and 92004 shall be limited to one (1) per recipient, per provider, per three (3) year period.

Established patient ophthalmological procedure codes 92012 and 92014 shall be limited to one (1) per recipient, per provider, per twelve (12) month period.

Procedure codes 92002, 92004, 92012, and 92014 shall NOT be reported and billed with the following procedure codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215.

Procedure codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215 shall not be reported and billed with the

SECTION IV - PROGRAM COVERAGE

Providers who perform any laboratory tests may request information or apply for CLIA certification at the following address:

ATTN CLIA LABORATORY INQUIRY
HEALTH CARE FINANCING ADMINISTRATION
PO BOX 26689
BALTIMORE MD 21207-0489

Upon receipt of CLIA certification and issuance of a CLIA number, individual optometrists providing laboratory services shall provide a copy of the CLIA certification of approval and the CLIA number to Department for Medicaid Services; Individual Provider Services Branch; 275 East Main; Frankfort, KY 40621. The individual optometrist shall report his Kentucky Medicaid eight (8) digit provider number at the same time to facilitate cross-referencing.

All optometrists enrolled in Kentucky Medicaid who are CLIA certified and have registered their CLIA certification numbers with Kentucky Medicaid Provider Enrollment may bill and receive reimbursement for the following laboratory procedures performed for Kentucky Medicaid recipients:

A complete blood count (CBC) shall be billed when three (3) or more of the following tests are performed: 85007 or 85009, 85014, 85018, 85041, or 85048. When a CBC is performed and billed to Kentucky Medicaid separate payment for any one (1) of these components shall not be allowed.

Reimbursement for both culture and smear for bacteria shall not be allowed by Kentucky Medicaid for the same diagnosis of a recipient, on the same date of service by the same provider.

Application of policy related to laboratory services shall be subject to enforcement by computer audits, edits and the postpayment review of claims.

SECTION IV – PROGRAM COVERAGE

C. Eyeglasses

1. Conditions of coverage

The following criteria shall be met for Kentucky Medicaid Program coverage of eyeglasses.

(a) Recipient's Age

The laboratory costs of eyeglasses or eyeglass parts and the appropriate dispensing fee for services provided for eligible Kentucky Medicaid Program recipients under twenty-one (21) years of age shall be payable by the Kentucky Medicaid Program.

(b) Diagnosis

Eligible recipients shall have a diagnosed visual condition that requires eyeglasses and is included in one (1) of the following four (4) categories:

(1) Amblyopia
(2) Post surgical eye condition
(3) Diminished or subnormal vision
(4) Other diagnosis which indicates need for eyeglasses

(c) Minimum Prescription

Visual conditions requiring prescriptions for correction shall contain power in the stronger lens no weaker than the following:

+0.50 or 0.50 sphere +0.50 or 0.50 cylinder
0.50 diopter of vertical prism
A total of 2 diopter of lateral prism

(d) Frame and Lenses Requirement

(1.) Frame

- All frames shall be first quality and free of defects. The material from which the frame is constructed shall be normally resistant to damage or breakage, and shall be finished with a high polish if indicated.

- To enable replacement of lenses and frame parts, all frames shall have imprinted on them the following information: Eye size, bridge size, temple length, and the manufacturer's name or trademark.

- The provider shall allow the recipient to try on and select from an adequate selection of appropriate, approved frame styles. The selection shall include a minimum of three (3) girl's and three (3) boy's frame styles, with three (3) sizes available in each style. The recipient shall be permitted to use his own frame, if he chooses. If the recipient selects frames non-approved by the Medicaid Program, the recipient shall be responsible for the payment of the frames. The Medicaid Program shall not pay the

D. Eyeglasses Coverage Limitations.

1. Reimbursement for eyeglasses shall not exceed:

(a) $200 per year for a recipient who is under age twenty-one (21) and a member of the global choices benefit plan; and

(b) $400 per year for a recipient who is under age twenty-one (21) and a member of the:

1. Family choices benefit plan;
2. Comprehensive choices benefit plan; or
3. Optimum choices benefit plan.

If medical necessity is established, these reimbursement caps do not apply to Early Periodic Screening, Diagnostic and Treatment (EPSDT) eligible children in accordance with 1905(r)(5) of the Social Security Act.

2. Changes in prescription shall meet a minimum of:

±0.50 sphere
±0.50 cylinder
1.00 cylinder or less-10° change in axis
1.25 cylinder or greater-5° change in axis

3. Telephone contacts shall be excluded from payment by Kentucky Medicaid.

4. Contact lenses shall be excluded from Kentucky Medicaid payment and shall not be substituted as eyeglasses. Procedure code 92070 shall be used to bill for the therapeutic bandage lens used in the treatment of diseases, (e.g., bullous keratopathy, or non-healing corneal ulcers). The fitting of contact lenses shall be payable **ONLY** when any one (1) of the following criteria is met:

   (a) The CORRECTED acuity in the recipient's best eye is 20/50 and shall be improved with use of contact lenses;

   (b) The visual prescription of ±8.00 diopter or greater;

   (c) The recipient diagnosis is 4.00 diopter anisometropia (difference in power between eyes); or

   (d) The words MEDICALLY INDICATED OR MEDICALLY NECESSARY shall be written or typed on the claim form. If this is not done, the provider must attach to the claim form a written or typed note or a formal attachment (e.g., the invoice or recipient medical record) stating that this method of correction is MEDICALLY INDICATED OR MEDICALLY NECESSARY. Documentation in the recipient's medical record shall substantiate why this method of correction was medically necessary or medically indicated.

5. Tint shall be payable by Kentucky Medicaid **ONLY** if the prescription specifically states the diagnosis of photophobia. This diagnosis shall be entered on the billing form. Include the tint cost within the cost of the lenses. This policy shall be subject to enforcement by postpayment review of claims.

6. Kentucky Medicaid Program reimbursement for eyeglasses shall be considered payment in full. The cost of both laboratory materials and dispensing fees may be billed to either the program or the recipient. If any portion of this fee billed to the recipient is paid by the recipient, Kentucky Medicaid shall not assume responsibility for payment of the same service and a claim shall not be submitted to Kentucky Medicaid

for additional payment. A claim for the same service may, however, be submitted to Kentucky Medicaid for payment if the provider refunds the amount paid by the recipient for the Kentucky Medicaid Program covered service **before** billing the program.

7. Safety glasses shall be payable **only** when medically indicated or medically necessary. The rationale for prescribing safety glasses shall be reported on the claim form, (e.g., recipient is blind in one (1) eye or has only one (1) eye); therefore, he requires additional protection for the remaining eye.

8. Press-on prism(s) shall be excluded from Kentucky Medicaid payment.

9. The cost of prism(s) when medically necessary shall be included within the cost of the lenses.

10. Low-Vision Services shall be excluded from Kentucky Medicaid payment.

E. Dispensing of Eyeglasses

The dispensing of eyeglasses shall include:

- Single vision prescriptions
- Bifocal (no trifocal) vision prescriptions
- Services to frames
- Delivery of completed prescription

1. SINGLE VISION PRESCRIPTIONS – The lens selection and design shall meet the recipient's physical, occupational, and recreational needs and requirements. The prescriber shall verify that the finished prescription lens power is correct as ordered and that lens specifications have been met. The prescriber shall be responsible for ascertaining that only first-quality eyeglass materials approved by the Kentucky Medicaid Program have been

provided for the Kentucky Medicaid Program recipients, and that the fabrication conforms to the standards.

THE PRESCRIBER SHALL BE RESPONSIBLE AT NO ADDITIONAL COST TO THE KENTUCKY MEDICAID PROGRAM OR THE RECIPIENT, FOR THE REPLACEMENT OF INACCURATELY FILLED PRESCRIPTIONS, NON-AUTHORIZED MATERIALS, DEFECTIVE MATERIALS, OR IMPROPERLY FITTING LENSES.

2. BIFOCAL PRESCRIPTIONS - Bifocal prescriptions shall have the same requirements as single vision prescriptions except when contraindicated.

3. SERVICES TO FRAMES. Services to frames shall include selecting frames, measuring the recipient's face for fitting, and fulfilling the recipient's occupational and recreational requirements. The provider shall allow the recipient to try on and select from an adequate number of appropriate, approved frame styles. The minimum number of frames for selection shall be three (3) girl's frame styles and three (3) boy's frame styles. Three (3) frame sizes of each style shall be available for selection by the recipient. The recipient shall be permitted to use his frame if he chooses. The provider shall verify that the finished prescriptions meet the frame specifications ordered and that only first-quality materials, approved by Kentucky Medicaid, have been provided for recipients. **THE PROVIDER SHALL BE RESPONSIBLE AT NO ADDITIONAL COST TO THE KENTUCKY MEDICAID PROGRAM OR THE RECIPIENT, FOR INACCURATELY FILLED PRESCRIPTIONS, NON-AUTHORIZED MATERIALS, DEFECTIVE MATERIALS, OR IMPROPERLY FITTING FRAMES.**

4. DELIVERY OF COMPLETED VISION PRESCRIPTION - Delivery of the completed prescription shall include instruction of the recipient in the use of the prescription, any adjustment of the prescription, and any subsequent minor adjustments for a period of one (1) year. These services shall be performed by the provider at no additional cost to the Kentucky Medicaid Program or the recipient.

F. Professional Services for Dispensing and Repairing Eyeglasses

Procedure codes for dispensing and repairing eyeglasses are contained in the American Medical Association **Physicians' Current Procedural Terminology (CPT) Book.** Codes from this source that are reimbursable by Kentucky Medicaid shall include 92340, 92341, 92352, 92353, and 92370.

Optometrists and opticians shall report their usual and customary charges for professional dispensing procedures when submitting claims to Kentucky Medicaid. Reimbursement shall be provided by Kentucky Medicaid **only** for recipients under twenty-one (21) years of age.

G. Eyeglass Procedure Codes

The following laboratory procedure codes and descriptions for eyeglasses and eyeglass parts shall be reimbursable by the Kentucky Medicaid Program and used when submitting claims for reimbursement.

CODE	PROCEDURE DESCRIPTION
V2020	Frames, Purchases
V2100	Sphere, Single Vision, Plano to Plus or Minus, 4.00, Per Lens
V2101	Sphere, Single Vision, Plus or Minus 4.12 to Plus or Minus 7.00D, Per Lens
V2102	Sphere, Single Vision, Plus or Minus 7.12 to Plus or Minus 20.00D, Per Lens
V2103	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2104	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2105	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2106	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, Over 6.00D Cylinder, Per Lens

V2207	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2208	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2209	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2210	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, Over 6.00D Cylinder, Per Lens
V2211	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 25 to 2.25D Cylinder, Per Lens
V2212	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 2.25 to 4.00D Cylinder, Per Lens
V2213	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2214	Spherocylinder, Bifocal, Sphere Over Plus or Minus 12.00D, Per Lens
V2215	Lenticular, (Myodisc), Per Lens, Bifocal
V2216	Lenticular, Nonaspheric, Per Lens, Bifocal
V2217	Lenticular, Aspheric Lens, Bifocal
V2218	Aniseikonic, Per Lens, Bifocal
V2219	Bifocal Seg Width Over 28mm
V2220	Bifocal Add Over 3.25D
V2299	Specialty Bifocal
V2410	Variable Sphericity Lens, Single Vision, Full Field, Glass or Plastic, Per Lens
V2430	Variable Sphericity Lens, Bifocal, Full Field, Glass or Plastic, Per Lens
V2499	Not Otherwise Classified, Variable Sphericity Lens
W0091	Hinge Repair
W0092	Two Temples Only
W0093	One Temple Only
W0094	Front Only

If a provider does his own laboratory work, the vision laboratory invoice may be his own letterhead paper with the breakdown of the lens cost (i.e., labor cost of materials, edging, hardening, coating, etc.). A copy shall be maintained in the recipient's medical records.

employed on a continuing basis by the Kentucky Medicaid participating provider. The Kentucky Medicaid provider under whose number the claim is submitted shall have provider-patient contact at some point during each treatment session billed. The professional shall be licensed in the state where he actively practices and the services provided shall be within the scope of that license.

The Kentucky Medicaid provider may not serve merely as a billing agent for a licensed medical professional or any agency that cannot otherwise be paid by the Kentucky Medicaid Program.

I. Consultation Services

Requests for consultation services from the attending provider and the need for consultation shall be documented in the recipient's medical record. The consultant's assessment, opinion, and any services ordered or performed shall also be documented in the recipient's medical record. This information shall be communicated **in writing** to the referring provider.

After an initial consultation in the consultant's office or other outpatient facility, follow-up visits **initiated by the consultant** shall be reported using office visit codes for established patients.

Initial inpatient consultations shall be limited to **ONE (1)** initial consultation per consultant provider, per recipient, per hospitalization.

If a consultant assumes responsibility for management of a portion or all of a recipient's healthcare, consultation codes shall not be used. In the hospital inpatient setting, the provider receiving the recipient for partial or complete transfer of care shall use the appropriate subsequent hospital care codes. In the office setting, the appropriate established patient codes shall be used.

The application of this policy shall be subject to enforcement by the postpayment review of claims.

REIMBURSEMENT

SECTION V

SECTION V - REIMBURSEMENT

A. Optometrists

Reimbursement of optometrists shall be in accordance with 907 KAR 1:631.

B. Opthalmic Dispensers

Reimbursement for opthalmic dispensers shall be in accordance with 907 KAR 1:631.

C. Laboratory Services

Providers who bill for clinical laboratory codes must comply with the requirements set forth in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). A copy of the CLIA certification must be sent to the Department for Medicaid Services, so that the CLIA number can be placed on the provider's file. Reimbursement for clinical laboratory services shall be based on the lesser of the providers usual and customary billed charges, or Medicare allowable payment rates. For laboratory codes which have no Medicare allowable fee on file, reimbursement shall be based on sixty-five (65) percent of the usual and customary actual billed charges.

D. Reimbursement in Relation to Medicare

1. Deductible and Coinsurance

Medicaid Program recipients who are **also eligible** for benefits under Title XVIII-Parts A and B (Medicare Hospital Insurance and Supplementary Medical Insurance) shall be required to utilize their benefits under Title XVIII (Medicare) prior to the availability of benefits under the Medicaid (Title XIX) Program. Title XVIII accepts primary liability for all payment sought.

receive a regular white Medical Assistance Identification card with QMB printed on the front, upper right portion of the card.

NOTE: On April 1, 1990, OBRA legislation mandated that assignment be accepted on all Medicare/Medicaid claims. This includes Qualified Medicare Beneficiary (QMB) claims. Unassigned claims submitted for coinsurance and deductible payments shall be denied for medical services provided on or after this April 1, 1990, date.

The Medicaid Program shall make payment for all Medicare deductible and coinsurance amounts for the time period any recipient is QMB or dually eligible.

E. Fees - Duplicate or Inappropriate

Effective July 1, 1994, the Kentucky Medicaid Program implemented a comprehensive, computerized auditing system for provider claims submitted for payment. The auditing system was designed to evaluate billing information and coding accuracy on claims submitted for payment to prevent duplicate or inappropriate payment. Based on coding criteria and protocols in the Physician's Current Procedural Terminology (CPT) code book introduced and published annually by the American Medical Association, this automated system of checking claims shall be utilized to detect miscoding and irregularities, i.e., unbundling which involves billing two (2) or more individual CPT codes that may be combined under a single code and charge, mutually exclusive procedures, incidental or integral procedures, etc. The logic of this oversight system shall supersede any Kentucky Medicaid audits or edits previously implemented. As complex developments in medical technology are introduced and require more specific coding, this automated, claim checking system shall be updated to assist in the processing and payment of claims for Kentucky Medicaid providers in a way more consistent with CPT and International Classification of Diseases (ICD-9) criteria.

If a recipient has retroactive eligibility in which the individual receives a back-dated Medicaid card, the provider of service shall maintain the option to accept the Kentucky Medicaid card. If the provider agrees to accept the card, any payments made to the provider by the recipient for services during the retroactive eligible period will require a 100 percent refund to the recipient before the program may be billed.

VISION PROGRAM MANUAL

APPENDIX

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

Following is a listing of the most frequently used diagnosis codes for vision care:

V53.1	Fitting and adjusting spectacles and contact lenses
V66.9	Follow-up Call (Convalescence - No diagnosis but referred back)
V68.1	Repair and adjusting spectacles
V72.0	Examination of eyes and vision
V80.2	Frame for Cataracts (Other eye conditions, screening for)

DIAGNOSIS CODE	DIAGNOSIS
360.4	Degenerated conditions of globe
360.40	Degenerated globe or eye, unspecified
360.41	Blind hypotensive eye
360.42	Blind hypertensive eye
360.43	Hemophthalmos, except current injury Excludes: traumatic (871.0-871.9, 921.0-921.9)
360.5	Retained (old) intraocular foreign body, magnetic Excludes: current penetrating injury with magnetic foreign body (871.5) retained (old) foreign body of orbit (376.6)
360.50	Foreign body, magnetic, intraocular, unspecified
360.51	Foreign body, magnetic, in anterior chamber
360.52	Foreign body, magnetic, in iris or ciliary body
360.53	Foreign body, magnetic, in lens
360.54	Foreign body, magnetic, in vitreous
360.55	Foreign body, magnetic, in posterior wall
360.59	Foreign body, magnetic, in other or multiple sites
360.6	Retained (old) intraocular foreign body, nonmagnetic Retained (old) foreign body:

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

365.65	Glaucoma associated with ocular trauma
365.8	Other specified forms of glaucoma
365.81	Hypersecretion glaucoma
365.82	Glaucoma with increased episcleral venous pressure
365.89	Other specified glaucoma
365.9	Unspecified glaucoma
366	Cataract Excludes: congenital cataract (743.30-743.34)
366.0	Infantile, juvenile, and presenile cataract
366.00	Nonsenile cataract, unspecified
366.01	Anterior subcapsular polar cataract
366.02	Posterior subcapsular polar cataract
366.03	Cortical, lamellar, or zonular cataract
366.04	Nuclear cataract
366.09	Other and combined forms of nonsenile cataract
366.1	Senile cataract
366.10	Senile cataract, unspecified
366.11	Pseudoexfolition of lens capsule
366.12	Incipient cataract
366.13	Anterior subcapsular polar senile cataract
366.14	Posterior subcapsular polar senile cataract
366.15	Cortical senile cataract
366.16	Nuclear sclerosis
366.17	Total or mature cataract
366.18	Hypermature cataract
366.19	Other and combined forms of senile cataract

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

366.9	Unspecified cataract
367	Disorders of refraction and accommodation
367.0	Hypermetropia
367.1	Myopia
367.2	Astigmatism
367.3	Anisometropia and aniseikonia
367.31	Anisometropia
367.32	Aniseikonia
367.4	Presbyopia
367.5	Disorders of accommodation
367.51	Paresis of accommodation
367.52	Total or complete internal ophthalmoplegia
367.53	Spasm of accommodation
367.8	Other disorders of refraction and accommodation
367.81	Transient refractive change
367.89	Other
367.9	Unspecified disorder of refraction and accommodation
368	Visual disturbances

Excludes: electrophysiological disturbances (794.11-794.14)

368.0	Amblyopia ex anopsia
368.00	Amblyopia, unspecified

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

368.6 Night blindness

368.60 Night blindness, unspecified
368.61 Congenital night blindness
368.62 Acquired night blindness
Excludes: that due to vitamin A deficiency (264.5)
368.63 Abnormal dark adaptation curve
368.69 Other night blindness

368.8 Other specified visual disturbances

368.9 Unspecified visual disturbance

369 Blindness and low vision

369.0 Profound impairment, both eyes

369.00 Impairment level not further specified
369.01 Better eye: total impairment
lesser eye: total impairment
369.02 Better eye: near-total impairment
lesser eye: not further specified
369.03 Better eye: near-total impairment
lesser eye: total impairment
369.04 Better eye: near-total impairment
lesser eye: near-total impairment
369.05 Better eye: profound impairment
lesser eye: not further specified
369.06 Better eye: profound impairment
lesser eye: total impairment
369.07 Better eye: profound impairment
lesser eye: near-total impairment
369.08 Better eye: profound impairment
lesser eye: profound impairment

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

lesser eye: moderate impairment

369.3 Unqualified visual loss, both eyes
Excludes: blindness, NOS:
legal [U.S.A. definition](369.4)
WHO definition (369.00)

369.4 Legal blindness, as defined in U.S.A.
Excludes: legal blindness with specification of impairment level (369.01[0]-369.08,369.11-369.14, 369.21-369.22)

369.6 Profound impairment, one eye

- 369.60 Impairment level not further specified
- 369.61 One eye: total impairment; other eye: not specified
- 369.62 One eye: total impairment; other eye: near-normal vision
- 369.63 One eye: total impairment; other eye: normal vision
- 369.64 One eye: near-total impairment; other eye: not specified
- 369.65 One eye: near-total impairment; other eye: near-normal vision
- 369.66 One eye: near-total impairment; other eye: normal vision
- 369.67 One eye: profound impairment; other eye: not specified
- 369.68 One eye: profound impairment; other eye: near-normal vision
- 369.69 One eye: profound impairment; other eye: normal vision

369.7 Moderate or severe impairment, one eye

- 369.70 Impairment level not further specified
- 369.71 One eye: severe impairment; other eye: not specified
- 369.72 One eye: severe impairment; other eye: near-normal vision
- 369.73 One eye: severe impairment; other eye: normal vision
- 369.74 One eye: moderate impairment; other eye: not specified
- 369.75 One eye: moderate impairment; other eye: near-normal vision
- 369.76 One eye: moderate impairment; other eye: normal vision

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

MODERATE VISUAL IMPAIRMENT

20.70 20/80 20/100 20/125 20/160 — Moderate low vision
0.25 0.20 0.16 0.12

SEVERE VISUAL IMPAIRMENT — Severe low vision, "Legal" blindness

20/200 20/250 20/320 20/400
0.10 0.08 0.06 0.05
Visual field: 20 degree or less

PROFOUND VISUAL IMPAIRMENT

20/500 20/630 20/800 20/1000 — Profound low vision, Moderate blindness
0.04 0.03 0.025 0.02
Count fingers at; less than 3m (10 ft.)
Visual field: degrees or less

NEAR-TOTAL VISUAL IMPAIRMENT

Visual acuity: less than 0.02 (20/1000 — Severe blindness

(U.S.A.) both eyes (WHO) one or both

Count fingers at: 1m (3 ft.) or less
Hand movements: 5m (15ft.) or less
Light project, light perception
Visual field: 5 degrees or less — Near-total blindness

TOTAL VISUAL IMPAIRMENT
No light perception (NLP) — Total blindness

Visual acuity refers to best achievable acuity with correction
Non-listed Snellen fractions may be classified by converting to the nearest decimal equivalent, e.g., 10/200 = 0.05, 6/30 = 0.20
CF (count fingers) without designation of distance, may be classified to profound impairment
HM (hand motion) without designation of distance, may be classified to near-total impairment

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

378.00	Esotropia, unspecified
378.01	Monocular esotropia
378.02	Monocular esotropia with A pattern
378.03	Monocular esotropia with V pattern
378.04	Monocular esotropia with other noncomitancies
378.05	Alternating esotropia
378.06	Alternating esotropia with A pattern
378.07	Alternating esotropia with V pattern
378.08	Alternating esotropia with other noncomitancies
378.1	Esotropia Excludes: intermittent exotropia (378.20, 378.23-378.24)
378.10	Exotropia, unspecified
378.11	Monocular exotropia
378.12	Monocular exotropia with A pattern
378.13	Monocular exotropia with V pattern
378.14	Monocular exotropia with other noncomitancies
378.15	Alternating exotropia
378.16	Alternating exotropia with A pattern
378.17	Alternating exotropia with V pattern
378.18	Alternating exotropia with other noncomitancies
378.2	Intermittent heterotropia Excludes: vertical heterotropia (intermittent) (378.31)
378.20	Intermittent heterotropia, unspecified
378.21	Intermittent esotropia, monocular
378.22	Intermittent exotropia, alternating
378.23	Intermittent exotropia, monocular
378.24	Intermittent exotropia, alternating
378.3	Other and unspecified heterotropia

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

378.71	Duane's syndrome
378.72	Progressive external ophthalmoplegia
378.73	Strabismus in other neuromuscular disorders
378.8	Other disorders of binocular eye movements Excludes: nystagmus (379.50-379.56)
378.81	Palsy of conjugate gaze
378.82	Spasm of conjugate gaze
378.83	Convergence insufficiency or palsy
378.84	Convergence excess or spasm
378.85	Anomalies of divergence
378.86	Internuclear ophthalmoplegia
378.87	Other dissociated deviation of eye movements
378.9	Unspecified disorder of eye movements
379.3	Aphakia and other disorders of lens Excludes: after-cataract (366.50-366.53)
379.31	Aphakia
379.32	Subluxation of lens
379.33	Anterior dislocation of lens
379.34	Posterior dislocation of lens
379.39	Other disorders of lens
379.4	Anomalies of pupillary function
379.42	Miosis (persistent), not due to miotics
379.43	Mydriasis (persistent), not due to miotics
379.45	Argyll Robertson pupil, atypical Excludes: Argyll Robertson pupil (Syphilitic) (094.89)

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

743.35	Congenital aphakia
743.36	Anomalies of lens shape
743.37	Congenital ectopic lens
743.39	Other
743.4	Coloboma and other anomalies of anterior segment
743.41	Anomalies of corneal size and shape Excludes: that associated with buphthalmos (743.22)
743.42	Corneal opacities, interfering with vision, congenital
743.43	Other corneal opacities, congenital
743.44	Specified anomalies of anterior chamber, chamber angle, and related structures
743.45	Aniridia
743.46	Other specified anomalies of iris and ciliary body
743.47	Specified anomalies of sclera
743.48	Multiple and combined anomalies of anterior segment
743.49	Other
871	Open wound of eyeball Excludes: 2nd cranial nerve injury (950.0-950.9) 3rd cranial nerve injury (951.0)
871.0	Ocular laceration without prolapse of intraocular tissue
871.1	Ocular laceration with prolapse of intraocular tissue
871.2	Rupture of eye with partial loss of intraocular tissue
871.3	Avulsion of eye
871.4	Unspecified laceration of eye
871.5	Penetration of eyeball with magnetic foreign body Excludes: retained (old) magnetic foreign body in globe (360.50-360.59)
871.6	Penetration of eyeball with (nonmagnetic) foreign body Excludes: retained (old) (nonmagnetic) foreign body in globe (360.60-360.69)

Kentucky Medicaid Program

Hearing Program Manual

Policies and Procedures

Cabinet for Health and Family Services
Department for Medicaid Services
Frankfort KY 40621

May 2006 Edition

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INTRODUCTION

SECTION I

SECTION I - INTRODUCTION

A. Introduction

The Kentucky Medicaid Hearing Program Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual contains basic information concerning coverage and policy. Precise adherence to policy shall be imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

The Kentucky Medicaid Program serves eligible recipients of all ages. Kentucky Medicaid coverage and limitations of covered health care services specific to the Hearing Program shall be specified in the body of this manual in Section IV.

KENTUCKY MEDICAID PROGRAM

SECTION II

SECTION II - KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients. The Medicaid Program shall be the payor of last resort. If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable charge.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid covered services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each eligible medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program in accordance with 907 KAR 1:672. From those professionals who have chosen to participate, recipients may select the provider from whom they wish to receive their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same services shall not be tendered to the

recipient, and a payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

The provider's adherence to the application of policies in this manual shall be monitored through either post-payment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to post-payment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Providers of medical service or authorized representative attest by their signatures (not facsimiles) on the claim form submitted, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment, or both. Stamped or computer generated signatures shall not be acceptable.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

B. Appeal Process for Refund Requests

Inappropriate overpayments to providers that are identified in the postpayment review of claims shall result in a refund request.

If a refund request occurs subsequent to a postpayment review by the Department for Medicaid Services or its agent, the provider may submit a refund to the Kentucky State Treasurer or appeal the Medicaid request for refund in writing by providing clarification and documentation that may alter the agency findings. This information relating to clarification shall be sent to:

DIVISION OF PROGRAM AND PROVIDER SERVICES
DEPARTMENT FOR MEDICAID SERVICES
CABINET FOR HEALTH SERVICES
275 EAST MAIN STREET
FRANKFORT, KENTUCKY 40621

If no response (refund or appeal) has been filed with Medicaid by the provider within thirty (30) days of the refund request, assent to the findings shall be assumed. If a refund check or request for a payment plan is not received within sixty (60) days, Medicaid shall deduct the refund amount from future payments.

C. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulation defines "Timely submission of claims" as received by Medicaid "no later than twelve (12) months

from the date of service." Received is defined in 42 CFR 447.45(d) (5) as follows, "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing **RECEIPT** by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. Claims shall not be considered for payment if more than twelve (12) months have elapsed between **EACH RECEIPT** of the aged claim by the Program.

D. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary care provider. The primary care provider shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

E. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, provider and recipients shall comply with the provision set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services.

Recipients assigned to the lock-in program shall have a pink MAID card and the name of the case manager shall appear on the face of the card.

F. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Under the EPSDT program, Medicaid eligible children, from birth through the end of the child's birth month of his twenty-first (21) year, may receive preventative, diagnostic and treatment services by participating providers. The goal of the program is to provide quality preventative health care by performing prescribed screenings at specified time intervals according to age (termed a periodicity schedule) to identify potential physical and mental heath problems. These screenings shall include a history and physical examination, developmental assessment, laboratory tests, immunizations, health education and other tests or procedures medically necessary to determine potential problems. Another goal of the program is to reimburse for medically necessary services ant treatments, even if the service or treatment is not normally covered by Kentucky Medicaid. However, the service or treatment must be listed in 42 USC Section 1396_d(a) which defines what services can be covered by state Medicaid programs. More information regarding the EPSDT program can be obtained by calling the EPSDT program within the Department for Medicaid Services.

G. Kentucky Health Care Partnership Program

In accordance with 907 KAR 1:705, the Department shall implement, within the Medicaid Program, a capitation managed care system for physical health services. The program places emphasis on access and continuity of care, quality assurance and improvement in health outcomes for participating Medicaid recipients. The Kentucky Health Care Partnership Program shall be implemented incrementally statewide beginning in 1997. Partnerships should be operational by January 1, 1999 or the state will begin a competitive bid process. Medicaid recipients residing in partnership regions and who are not recipients of Medicaid long term care services shall be eligible to receive Medicaid services through regional partnerships. If a health care provider chooses to provide Medicaid services through the Kentucky Care Partnership Program the provider shall enroll in a regional partnership as a Medicaid network provider. The provider shall agree to provide, or arrange for the provision of, all

Medicaid covered services in accordance with the terms and conditions specified by the Department. The provider shall also agree to the terms, conditions, and administrative procedures specified by the partnership related to the delivery of services. Healthcare providers may contact the Department for Medicaid Services for additional information relating to Medicaid services under the Kentucky Health Care Partnership Program.

H. Kentucky ACCESS

In accordance with 907 KAR 1:710, the Department shall implement, within the Medicaid Program, a capitation managed behavioral health care system called Kentucky ACCESS. Kentucky ACCESS shall be implemented on a regional basis, much like the physical health partnership regions. Services covered under Kentucky ACCESS will generally include those services provided by psychiatrists, community mental health centers, psychiatric hospital units and psychiatric residential treatment facilities (PRTF), except for children in the EPSDT program. It also includes other medically necessary services such as services for alcohol and substance abuse.

I. EMPOWER Kentucky Transportation Initiative

In accordance with 907 KAR 3:065, the Department shall implement, within the Medicaid Program, as an EMPOWER Kentucky initiative, a capitation non-emergency medical transportation delivery system. The Department has entered into a contract with three other Cabinets to implement this program incrementally statewide beginning in June 1998. This new system is designed to extend service to areas of the state currently under-served, provide transportation alternatives to more people, encourage efficiency and discourage fraud and abuse.

CONDITIONS OF PARTICIPATION

SECTION III

SECTION III - CONDITIONS OF PARTICIPATION

A. General Information

For purposes of participation in the Kentucky Medicaid Program, an eight (8) digit Medicaid provider number shall be assigned to each provider. Hearing Aid Dealer provider numbers have a prefix of "50" and clinic provider numbers have a prefix of "509". Audiologist provider numbers have a prefix of "70" and clinic provider numbers have a prefix of "709". Failure to report the correct provider number on the claim submitted for services provided may result in incorrect or nonpayment of claims. If a provider is terminated from Kentucky Medicaid participation, services provided to Kentucky Medicaid recipients after the effective date of termination shall not be payable.

B. Licensure

All hearing aid dealers shall have a current, unrevoked and unsuspended license issued by the Kentucky Licensing Board for Specialist in Hearing Instruments under requirements set forth in KRS Chapter 334 or hold a current, unrevoked, and unsuspended certificate of endorsement. Annual proof of licensure renewal (which includes effective date and expiration date) shall be required and submitted to the Kentucky Medicaid Program, Provider Enrollment Section, Individual Provider Services Branch, for providers who desire to remain actively enrolled. All audiologists shall have and be required to submit proof of a current, unrevoked, unsuspended Kentucky audiologist license issued by the State Board of Examiners for Speech Pathology and Audiology under KRS Chapter 334. Out-of-State audiologists shall be required to submit proof of a Certificate of Clinical Competence issued by the American Speech and Hearing Association, as well as appropriate license(s) as required by their state. Annual proof of licensure renewal (which includes effective date and expiration date) shall be required and submitted to the Kentucky Medicaid Program, Provider Enrollment Section, Individual Provider Services Branch, for providers who desire to remain actively enrolled.

NOTE: Non-submission of proof of current licensure shall result in loss of eligibility of the provider and denial of claims submitted for payment.

C. Clinics

Kentucky Medicaid shall permit a group of hearing aid dealers or audiologists to enroll in the Program as a clinic under certain conditions. A **clinic** shall be defined by Kentucky Medicaid as a group of several providers who practice cooperatively and collaboratively, and who perform a majority of their services in the primary care setting.

Hearing aid dealers or audiologists who are employed and salaried by a clinic may request that payment for their individual services provided for eligible Kentucky Medicaid Program recipients be made directly to the clinic. Each shall be required to sign and submit a Statement of Authorization Form, (MAP-347).

D. Freedom of Choice Concept

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid recipients and to bill the program for the medical care provided.

PROGRAM COVERAGE

SECTION IV

SECTION IV - PROGRAM COVERAGE

COVERAGE REQUIREMENT

(1) Prior to the delivery of a covered hearing or vision service, the service shall be determined by the department to be:

(a) Medically necessary; and

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.

(2) The requirements established in subsection (1) of this section shall not apply to an emergency service.

SECTION IV - PROGRAM COVERAGE

Limited Audiology and Hearing Aid Services shall be covered for eligible Kentucky Medicaid Program recipients under twenty-one (21) years of age. Eligible recipients are limited to one (1) hearing aid per ear annually, not to exceed a total cost of $1,400 per ear every thirty-six (36) months. Recipients will be responsible for any hearing aid charges over $1,400 per ear every thirty-six (36) months.

A. Audiology Services

1. Eligibility Guidelines

Medical Assistance Identification (MAID) cards shall be issued to all recipients eligible for Program benefits. The ten (10) digit MAID number which appears on the identification card shall be entered in Field 9a on the HCFA-1500 claim form submitted for payment. The patient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the patient's name appears on the card and that the card is valid for the period of time in which the services are to be rendered. If there is any doubt about the identity of the patient, you may request a second form of identification. A provider cannot be paid for services rendered to an ineligible person. Failure to validate the identity of a Medicaid recipient prior to a service being rendered may result in being out of compliance with KAR 1:671. Any claims paid by Medicaid Services on behalf of an ineligible person may be recouped from the provider.

2. Hearing Evaluations

a. One (1) audiologist or hearing clinic hearing evaluation per year shall be covered for eligible Kentucky Medicaid Program recipients under twenty-one (21) years of age.

b. One (1) audiologist or hearing clinic hearing aid evaluation per year when indicated as a result of the hearing evaluation shall be covered for eligible Kentucky Medicaid Program recipients under twenty-one (21) years of age.

3. Follow-Up Services

a. After a hearing aid has been fitted as a result of a hearing evaluation, three (3) follow-up visits within six (6) months shall be allowed for eligible Kentucky Medicaid recipients. To insure that the recipient has become properly adjusted to the hearing aid the follow-up care shall include counseling and instructing the recipient and family as to proper use and care of the aid, plus attention to

any psycho-social problems resulting from loss of hearing and the wearing of the aid.

b. After final fitting of the hearing aid, a required six (6) month follow-up visit to the audiologist or hearing aid clinic shall be allowed for eligible Kentucky Medicaid recipients.

4. Equipment Guidelines

Equipment utilized in performance of hearing tests shall meet American National Standard Institute (ANSI) Standards and Specification.

The audiometer shall be checked at least once per year to assure proper functioning. Proof of calibration and repairs shall be available for review. The audiometer shall be checked periodically by a listening test by the individual who performed the testing as that individual shall be familiar with the levels of hearing response.

5. Audiology Procedure Codes

The following procedure codes and descriptions for audiology services shall be reimbursable to audiologists by the Kentucky Medicaid Program and used when submitting claims for reimbursement.

CODE	PROCEDURE DESCRIPTION
V5000	Audiometric Exam - Hearing Exam Including the Measuring of Hearing Acuity and Tests Relating to Air Conduction, Bone Conduction, Speech Reception, Threshold and Speech Discrimination
V5010	Hearing Aid Evaluation Test
V5020	Conformity Evaluation (Up to Three (3) Visits Within Six (6) Month Period)
W0030	Six (6) Month Follow-Up Visit

NOTE: Audiology claims submitted for the above referenced covered procedures shall reflect the usual and customary general public charge. Audiology services shall be provided by Kentucky Medicaid **only** for recipients under twenty-one (21) years of age.

6. Hearing Aid Recommendation

If a hearing aid is needed as a result of the hearing evaluation and the hearing aid evaluation, the audiologist shall recommend that an aid be fitted for the recipient and given the following papers:

a. A signed and dated statement of medical necessity from the examining physician and

b. A signed and dated recommendation for a hearing aid to include the make and model of the hearing aid. The recipient shall be instructed to take the papers to a Kentucky Medicaid participating hearing aid dealer to obtain the recommended hearing aid.

7. Hearing Aid Replacement

Reimbursement to Kentucky Medicaid participating audiologists or hearing clinics for a complete re-evaluation of a hearing loss shall be made when loss of or extensive damage to a hearing aid purchased through the Medicaid Program necessitates replacement of the aid.

a. If replacement of a hearing aid becomes necessary within twelve (12) months of the original fitting, the second aid shall be fitted upon the signed and dated recommendation of the audiologist.

b. If replacement of a hearing aid becomes necessary after one (1) year or more of the original fitting, the recipient shall be examined by a physician and the hearing loss re-evaluated by an audiologist.

c. If medical, physical, or other conditions pertinent to the recipient's hearing loss change to an extent that use of a hearing aid other than the aid originally fitted is indicated, the Kentucky Medicaid Program shall reimburse the audiologist or

center for a complete re-evaluation of the hearing loss if the required signed and dated statement of medical clearance from the examining physician states the condition.

8. Services Not Covered

Services not covered by Kentucky Medicaid shall include the following:

- Routine screening of individuals or groups for identification of hearing problems. Program coverage extends only to those hearing evaluations performed when the recipient has been referred to the audiologist or hearing clinic by a physician or when there has been some indication of hearing loss prior to the evaluation.
- Hearing therapy except as covered through six (6) month adjustment counseling following fitting of a hearing aid.
- Lip reading instructions, except as covered in six (6) month adjustment counseling following fitting of a hearing aid.
- Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment (e.g., transportation of equipment for testing fee).
- Services provided for eligible recipients who are over twenty-one (21) years of age.
- Telephone calls.
- Services associated with investigational research.

B. Hearing Aid Services

1. Eligibility Guidelines

Hearing Aid Services shall be covered for eligible Kentucky Medicaid Program recipients under twenty-one (21) years of age. Medical Assistance Identification (MAID) cards shall be issued to all recipients eligible for program benefits. The ten (10) digit MAID number which appears on the identification card shall be

entered in Field 9a on the HCFA-I500 claim form submitted for payment. The patient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the patient's name appears on the card and that the card is valid for the period of time in which the services are to be rendered. If there is any doubt about the identity of the patient, you may request a second form of identification. A provider cannot be paid for services rendered to an ineligible person. Failure to validate the identity of a Medicaid recipient prior to a service being rendered may result in being out of compliance with 907 KAR 1:671. Any claims paid by Medicaid Services on behalf of an ineligible person may be recouped from the provider.

a. Reimbursement to a Kentucky Medicaid participating hearing aid dealer for hearing aids provided to an eligible recipient shall be made by Kentucky Medicaid after the recipient has been examined by a licensed physician, and after a licensed audiologist has verified the recipient's hearing loss and recommended that a hearing aid is necessary to improve the recipient's hearing ability. Examinations by the physician and recommendations by the audiologist shall be provided within ninety (90) days prior to the hearing aid fitting. (This ninety (90) day period begins on the date of the physician's examination or the audiologist's evaluation, whichever is earlier.) The hearing aid dealer shall provide the recipient with hearing aids specifically recommended by the audiologist. Hearing aid coverage is limited to recipients under age twenty-one (21) and shall not exceed $1,400 per ear every thirty-six (36) months. Recipients will be responsible for any hearing aid charges over $1,400 per ear every thirty-six (36) months.

b. If a recipient loses a hearing aid purchased through the Medicaid Program or an aid is damaged to an extent which makes effective repair impossible, Kentucky Medicaid can make payment for a replacement hearing aid. In case of extensive damage, written verification shall be obtained from the manufacturer attesting to the impossibility of repair of the aid.

1. If replacement of a hearing aid becomes necessary within one (1) year of the original fitting, the recipient shall return to an audiologist for consultation and specific aid recommendation if other than the aid is replaced.

2. If replacement of a hearing aid becomes necessary after one (1) year or more, a hearing examination of the recipient by a physician and an audiologist re-evaluation and hearing aid recommendation shall be required prior to fitting of the replacement aid.

c. If medical, physical, or other conditions pertinent to the recipient's hearing loss change to an extent that use of a hearing aid other than the aid originally fitted is indicated, Kentucky Medicaid shall reimburse the hearing aid dealer for the second hearing aid if the recipient has been examined by a physician for the hearing loss and recommendations for fitting of the replacement aid have been received from an audiologist.

1. Replacement of a hearing aid shall not be covered upon only the request by the recipient.

2. Replacement of a hearing aid for the purpose of incorporating recent improvements or innovations in hearing aids shall not be covered, unless the replacement will result in appreciable improvement in the recipient's hearing ability, as determined by evaluation of an audiologist. In these cases, an audiologist's explanation shall accompany the hearing aid dealer's billing for the fitting.

NOTE: Kentucky Medicaid Program reimbursement for hearing aids shall be considered payment in full for the initial, successful operation of the instrument, plus general service to the instrument for a period of one (1) year. General service shall include any cleaning, adjustment, and minor repairs to the instrument, that do not necessitate return of the instrument to the manufacturer. If Program payment is requested the hearing aid dealer shall agree to accept this payment as "payment in full" for the items and services, even though the amount of Program reimbursement is less than the usual and customary charge for the hearing aid. A claim shall not be submitted to Kentucky Medicaid for additional payment. Recipients shall not be billed for any difference in costs.

Kentucky Medicaid Program reimbursement to a hearing aid dealer for hearing aid repairs, replacement of a hearing aid, and hearing aid replacement cords shall be contingent upon the recipient's eligibility for Medicaid benefits on the date of the service or date the item is supplied. If a recipient is not eligible on the date of service, reimbursement for the service provided shall not be made.

2. Hearing Aid Cords

Hearing aid replacement cords necessary for proper functioning of the hearing aid shall be payable by Kentucky Medicaid.

3. Hearing Aid Repairs

Kentucky Medicaid Program reimbursement to the hearing aid dealer shall be made **only** for necessary repairs to the hearing aid, if repairs entail replacement of vital components of the aid and necessitate return of the aid to the manufacturer. Reimbursement shall not be made for repairs normally covered by the manufacturer's guarantee.

4. Eyeglass Hearing Aids

If the recipient is diagnosed with refractive error and the audiologist recommends an eyeglass hearing aid, Kentucky Medicaid Program reimbursement shall be made for the hearing aid and the eyeglass temples **only**. Other financial arrangements for payment of incurred cost of eyeglass fronts and lenses shall be made by the provider.

5. Hearing Aid Procedure Codes

The following procedure codes and descriptors for hearing aids and hearing aid parts shall be reimbursable to hearing aid dealers by the Kentucky Medicaid Program and shall be used when submitting claims for reimbursement.

V5030	Hearing Aid, Monaural, Body Worn, Aid Conduction
V5040	Hearing Aid, Monaural, Body Worn, Bone Conduction
V5050	Hearing Aid, Monaural, In The Ear
V5060	Hearing Aid, Monaural, Behind The Ear
V5170	Hearing Aid, Cros, In The Ear
V5180	Hearing Aid, Cros, Behind The Ear
V5210	Hearing Aid, Bicros, In The Ear
V5220	Hearing Aid, Bicros, Behind The Ear

W0073	Earmold (Shall be billed **only** with V5030, V5040, V5050, V5060, V5170, V5180, V5210, and V5220)
W0074	Battery (Shall be billed **only** with V5030, V5040, V5050, V5060, V5170, V5180, V5210, and V5220)
W3051	Replacement Cord
W3052	Hearing Aid Repair Cost
W0075	Adaptation of the hearing aid for use with a Bone Oscillator and Headband (shall be billed **only** with V5030, V5040, V5050, V5060, V5170, V5180, V5210, and V5220)

Claims submitted for the above referenced covered hearing aid and hearing aid parts shall reflect the actual laboratory cost of the materials. The physician statement of medical clearance, the audiologist hearing aid recommendation, and manufacturers invoice verifying the actual costs of materials shall be attached to claims submitted for payment. Reimbursement shall be provided by Kentucky Medicaid **only** for recipients under twenty-one (21) years of age.

6. Professional Services for Dispensing, Replacing, and Repairing Hearing Aids

Claims submitted for the following procedure codes and descriptors for hearing aid professional services shall reflect the usual and customary professional dispensing charges of the hearing aid dealer. Reimbursement shall be provided by Kentucky Medicaid **only** for recipients under twenty-one (21) years of age.

V5160	Hearing Aid Dispensing Fee (2 Aids)
V5090	Hearing Aid Dispensing Fee (1 Aid)
W0080	Hearing Aid Replacement Cord Professional Fee
W0090	Hearing Aid Repair Professional Fee

7. Services Not Covered

Services not covered by Kentucky Medicaid shall include the following:

a. Replacement batteries

b.	Replacement earmold
c.	Telephone switches, unless built in by manufacturer as standard part of hearing aid and included in standard charge for hearing aid.
d.	Devices for listening to radio and television.
e.	Other accessories not usually part of a standard hearing aid and unnecessary for basic operation of a hearing aid.
f.	Preparations for cleaning hearing aids.
g.	Ointments and drops for relief of irritation caused by wearing the hearing aid.
h.	Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment (e.g., transportation of equipment for testing fee).
i.	Hearing and audiology services for eligible recipients who are over twenty-one (21) years of age.
j.	Duplicate services.
k.	Procedures not approved.
l.	Telephone calls.
m.	Services associated with investigational research.

REIMBURSEMENT

SECTION V

SECTION V - REIMBURSEMENT

A. Audiologists

Reimbursement of audiologists shall be in accordance with 907 KAR 1:039.

B. Hearing Aid Dealers

Reimbursement for hearing aid dealers shall be in accordance with 907 KAR 1:039.

C. Reimbursement in Relation to Medicare

1. Deductible and Coinsurance

Medicaid Program recipients who are **also eligible** for benefits under Title XVIII-Parts A and B (Medicare Hospital Insurance and Supplementary Medical Insurance) shall be required to utilize their benefits under Title XVIII (Medicare) prior to the availability of benefits under the Medicaid (Title XIX) Program. Title XVIII accepts primary liability for all payment sought.

Deductibles are those medical expenses which the recipient shall initially pay on an annual basis to qualify for subsequent Medicare reimbursement. Coinsurance is a cost-sharing requirement which provides that a recipient shall assume a portion or percentage of the costs of covered services. Medicaid shall pay the Medicare deductible and coinsurance amounts for all Medicare covered services submitted on cross-over claims for eligible recipients.

The Medicaid Program shall make payments on behalf of those Title XIX recipients who are **also entitled** to benefits under Medicare Title XVIII-Part A of Public Law 89-97. The Medicaid Program shall pay the deductible and coinsurance amounts as determined by Medicare.

2. Qualified Medicare Beneficiary

Effective February 1, 1989, Section 301 of the Medicare Catastrophic Coverage Act of 1988 requires states to provide Medicaid coverage to certain Medicare beneficiaries in order to pay Medicare cost-sharing expenses (premium, deductible coinsurance amounts). Individuals entitled to Medicare Part A and who do not exceed federally-established income and resource standards may be eligible to receive Medicaid benefits as Qualified Medicare Beneficiaries (QMB's). These individuals receive unique, tricolored (red, white, blue) identification cards. Reimbursable services for QMB recipients shall be limited to coinsurance and deductibles for all Medicare (Parts A and B) covered services or items regardless of whether the services or items are routinely covered by Kentucky Medicaid.

3. Dual Eligibility for QMB and Medicaid

The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) further provides that specified individual meeting income and resource standards for QMB and also meeting Medicaid eligibility criteria shall have dual eligibility for QMB benefits and Medicaid benefits. These individuals receive a regular white Medical Assistance Identification card with QMB printed on the front, upper right portion of the card.

NOTE: On April 1, 1990, OBRA legislation mandated that assignment be accepted on all Medicare/Medicaid claims. This includes Qualified Medicare Beneficiary (QMB) claims. Unassigned claims submitted for coinsurance and deductible payments shall be denied for medical services provided on or after this April 1, 1990, date.

The Medicaid Program shall make payment for all Medicare deductible and coinsurance amounts for the time period any recipient is QMB or dually eligible.

D. Fees - Duplicate or Inappropriate

Effective July 1, 1994, the Kentucky Medicaid Program implemented a comprehensive, computerized auditing system for provider claims submitted for payment. The auditing system was designed to evaluate billing information and coding accuracy on claims submitted for payment to prevent duplicate or inappropriate payment. Based on coding criteria and protocols in the Physician's Current Procedural Terminology (CPT) code book introduced and published annually by the American Medical Association, this automated system of checking claims shall be utilized to detect miscoding and irregularities, i.e., unbundling which involves billing two (2) or more individual CPT codes that may be combined under a single code and charge, mutually exclusive procedures, incidental or integral procedures, etc. The logic of this oversight system shall supersede any Kentucky Medicaid audits or edits previously implemented. As complex developments in medical technology are introduced and require more specific coding, this automated, claim checking system shall be updated to assist in the processing and payment of claims for Kentucky Medicaid providers in a way more consistent with CPT and International Classification of Diseases (ICD-9) criteria.

Any duplicate or inappropriate payments issued by Kentucky Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Kentucky Medicaid. Refund checks shall be made payable to "Kentucky State Treasurer" and sent to the fiscal agent.

Failure to refund a duplicate or inappropriate payment shall be interpreted as fraud or abuse, and therefore, subject to prosecution.

SECTION V - REIMBURSEMENT

E. Fee Payment By Recipient

Participants in the program shall report **ALL** payments or deposits made toward a recipient's account, regardless of the source of payment. If the provider receives payment from an eligible Medicaid Program recipient for a Medicaid covered service, the Medicaid Program regulations preclude payment being made by the program for that service unless documentation is received that the payment has been refunded to the recipient. This policy shall not apply to payments made by recipients for spenddown or non-covered services.

Recipients approved for Medicaid benefits on a spend down basis shall be obligated to pay fees to health care providers as assigned by their local Department for Social Insurance where eligibility is established. These fees shall be paid to the providers by the recipients and shall satisfy the excess income for the period of eligibility. These fee payments by the recipients shall be reported by the providers on the claim form as payments from other sources.

Any item(s) or service(s) provided for Medicaid recipients non-covered by Kentucky Medicaid may be billed to the recipient or any other responsible party. Providers shall not collect fees from recipients for covered item(s) or service(s) for which Kentucky Medicaid has made payment. Any payment made by Kentucky Medicaid shall be accepted by the provider as payment in full for a service.

If a recipient has retroactive eligibility in which the individual receives a back-dated Medicaid card, the provider of service shall maintain the option to accept the Kentucky Medicaid card. If the provider agrees to accept the card, any payments made to the provider by the recipient for services during the retroactive eligible period will require a 100 percent refund to the recipient before the program may be billed.

HEARING PROGRAM MANUAL

APPENDIX

DIAGNOSIS CODES FREQUENTLY USED FOR HEARING CARE

Following is a listing of the most frequently used diagnosis codes for hearing care:

V53.2 Fitting and adjusting hearing aids
V72.1 Examination of ears and hearing

Hearing Loss

389.0 Conductive hearing loss
Conductive Deafness

389.00 Conductive hearing loss, unspecified
389.01 Conductive hearing loss, external ear
389.02 Conductive hearing loss, tympanic membrane
389.03 Conductive hearing loss, middle ear
389.04 Conductive hearing loss, inner ear
389.08 Conductive hearing loss of combined types

389.1 Sensorineural hearing loss
Perceptive hearing loss or deafness
Excludes: abnormal auditory perception (388.40-388.44)
psychogenic deafness (306.7)
389.10 Sensorineural hearing loss, unspecified
389.11 Sensory hearing loss
389.12 Neural hearing loss
389.14 Central hearing loss
389.15 Sensorineural hearing loss of combined types
389.2 Mixed conductive and sensorineural hearing loss
Deafness or hearing loss of type classifiable to 389.0 with type classifiable to 389.1
389.7 Deaf mutism, not elsewhere classifiable
Deaf, nonspeaking
389.8 Other specified forms of hearing loss
389.9 Unspecified hearing loss

DIAGNOSIS CODES FREQUENTLY USED FOR HEARING CARE

Deafness NOS

Hearing Severity Definitions

0-25 db - Normal
26-45 db - Mild
46-70 db - Moderate
70-93 db - Severe
93 db plus - Profound